STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155160	A. BUILDING 00 B. WING	01/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEBROOKE REHABILITATION CENTRE & SUITES	990 N 16TH ST NEW CASTLE, IN 47362

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for the Investigation of Complaint IN00101785, Complaint IN00102884 and Complaint IN00103027. Complaint IN00101785 -- Substantiated. No deficiencies related to the allegations are cited. Complaint IN00102884 -- Substantiated. Federal/State deficiencies related to the allegations are cited at F157 and F514. Complaint IN00103027 -- Substantiated. No deficiencies related to the allegations are cited. Survey dates: January 23, 24, 25, and 26, 2012 Facility number: 000080 Provider number: 155160 AIM number: 100289330 Survey team: Penny Marlatt, RN Census bed type: SNF/NF: 79 Total: 79 Census payor type: Medicare: 15 Medicaid: 52	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Other: 12 Total: 79 Sample: 5 Supplemental Sample: 4 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2. Quality review completed 1/31/12 Cathy Emswiller RN			

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F0157 SS=D	A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.			
	Based on interview and record review, the facility failed to ensure the recommendations from the Registered Dietitian (RD) for gastric feeding and water flushes were forwarded to the physician for approval and signature prior to instituting the recommendations	F0157	**F157 Notification of changes** **What**	02/06/2012

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	for 1 of 2 residents reviewed for gastric feeding tubes in a total sample of 5. (Resident #D) Findings include: Resident #D's clinical record was reviewed on 1-24-12 at 8:27 a.m. His diagnoses included, but were not limited to cerebrovascular accident (CVA) with history of multiple CVA's with most recent indicated to have occurred December, 2011, diabetes, congestive heart failure (CHF), multi-infarct dementia, dysphagia, craniotomy as a result of a subdural hematoma (bleeding in the brain) in April 2010 following heart surgery, depression, gastrostomy-Jejunostomy tube (GT-JT or feeding tube) and aphasia. Review of Resident #D's physician orders for 1-17-12 indicated a telephone order which indicated gastric feeding fluids and water flushes only as "per RD rec[ommendations.]" The telephone orders did not specify what those recommendations were. The RD had specified the recommendations in a progress note, dated 1-17-12 at 12:09 p.m. The RD's recommendations indicated to continue the enteral feeding of Glucerna 1.2 diabetic formula at 65 cc (cubic centimeters) per hour via the JT, but to		**corrective action(s) will be** **Accomplished for those residents Found to have been affected by the Deficient practice:** ·Resident D's physician was notified of the Dietary recommendation and an order is now in place. **How will you identify other residents** **Having the potential to be affected by the same deficient practice and what corrective action will be taken:** ·All residents have the potential to be affected by the alleged deficient practice. ·The licensed nurses will be re-educated by the DNS/designee (2/7/12)) on notification of a resident's physician for Dietary recommendations including approval prior to documenting in the medication administration and institution of the recommendation. Post test included. ·Any other residents that received dietary recommendations were reviewed and orders received. If physician does not agree with dietary recommendations dietary orders were obtained. ·Dietary recommendations will	

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	change the water flushes of the tubing's to 30 cc before and after medication administration via the GT and an additional 120 cc of water every 4 hours via the GT. The RD recommended to flush the JT with 60 cc of water prior to hanging a new Glucerna feeding bottle via the JT. The water flush recommendations were different than the previous water flush orders. Previous orders, dated 1-10-12, indicated to provide 300 cc of water every 6 hours. These new recommendations were indicated to have been documented on the Medication Administration Record (MAR) as specified by the RD in the progress note and were documented by the nursing staff as being conducted as according to the RD's recommendations, effective on 1-17-12. In interview with the Staff Development Nurse on 1-24-12 at 10:25 a.m., she indicated she had "found the current flush orders for the G-tube and the J-tube on the MAR, but no [physician] order for it...looks like whoever did the MAR didn't get the recommendations sent to the doctor to sign." She indicated the facility normally would have the RD provide her recommendations, then those recommendations would be faxed to the physician for their signature or would		be given to the DNS/designee by the RD prior to RD exit day of visit. ·The director of nursing services/designee is responsible to ensure compliance **What measures will be put into place or what systemic changes you will make to ensure the deficient practice does not recur:** · The licensed nurses will be re-educated by the DNS/designee (2/7/12) on notification of a resident's Physician for Dietary recommendations including approval prior to documenting in the medication administration and institution of the recommendation. Post test included. ·Dietary recommendations will be given to the DNS/designee by the RD prior to RD exit day of visit to obtain physician order. ·Every recommendation will be given to the DNS to ensure proper follow-up of physician's orders. ·The director of nursing services/designee is responsible to ensure compliance. ·Non-compliance will result in further education including disciplinary action. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur:** ·The CQI audit tool for Dietary recommendations as well as change of condition will be utilized daily x 4 weeks, bi-weekly x 2	

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	have the physician sign an order for the recommendations when the physician was in the facility. She indicated she would ensure a clarification order would be forwarded to the physician in regard to the feeding and flush orders, based on the RD's recommendations. In interview with the Director of Nursing Services on 1-26-12 at 10:32 a.m., she indicated the facility does not have a specific policy which indicated "clear and accurate documentation." The Medical Records Director provided a policy on 1-26-12 at 11:26 a.m. entitled, "Documentation Guidelines," with a revision date of 2/2011. This policy indicated, "Purpose: To accurately document in an organized manner all information related to the resident in the medical record." This Federal tag relates to Complaint IN00102884. 3.1-5(a)(3)		months, monthly x 3 months and for 2 quarters thereafter for any resident who receives a dietary recommendation. ·Findings from the CQI process will be reviewed monthly and an action plan will be implemented for threshold below 95%. **Date of Compliance: 2/6/2012**	

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F0514 SS=D	The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.			
	Based on interview and record review, the facility failed to ensure the recommendations from the Registered Dietitian (RD) for gastric feeding and water flushes were forwarded to the physician for approval and signature prior to documenting the recommendation on the medication administration record and instituting the recommendations for 1 of 2 residents reviewed for gastric feeding tubes in a total sample of 5. (Resident #D) Findings include: Resident #D's clinical record was reviewed on 1-24-12 at 8:27 a.m. His diagnoses included, but were not limited to cerebrovascular accident (CVA) with history of multiple CVA's with most recent indicated to have occurred December, 2011, diabetes, congestive heart failure (CHF), multi-infarct dementia, dysphagia, craniotomy as a	F0514	**F-514 Records-complete/accurate/accessible** **What corrective action(s) will be** **Accomplished for those residents Found to have been affected by the Deficient practice:** ·Resident D's physician was notified of the Dietary recommendation and an order is now in place. **How will you identify**	02/06/2012

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	result of a subdural hematoma (bleeding in the brain) in April 2010 following heart surgery, depression, gastrostomy-Jejunostomy tube (GT-JT or feeding tube) and aphasia. Review of Resident #D's physician orders for 1-17-12 indicated a telephone order which indicated gastric feeding fluids and water flushes only as "per RD rec[ommendations.]" The telephone orders did not specify what those recommendations were. The RD had specified the recommendations in a progress note, dated 1-17-12 at 12:09 p.m. The RD's recommendations indicated to continue the enteral feeding of Glucerna 1.2 diabetic formula at 65 cc (cubic centimeters) per hour via the JT, but to change the water flushes of the tubing's to 30 cc before and after medication administration via the GT and an additional 120 cc of water every 4 hours via the GT. The RD recommended to flush the JT with 60 cc of water prior to hanging a new Glucerna feeding bottle via the JT. The water flush recommendations were different than the previous water flush orders. Previous orders, dated 1-10-12, indicated to provide 300 cc of water every 6 hours. These new recommendations were indicated to have been documented on the		**other residents** **Having the potential to be affected by the same deficient practice and what corrective action will be taken:** ·All residents have the potential to be affected by the alleged deficient practice. ·The licensed nurses will be re-educated by the DNS/designee (2/7/12)) on notification of a resident's physician for Dietary recommendations including approval prior to documenting in the medication administration and institution of the recommendation. Post test included. ·Any other residents that received dietary recommendations were reviewed and orders received. If physician does not agree with dietary recommendations dietary orders were obtained. ·Dietary recommendations will be given to the DNS/designee by the RD prior to RD exit day of visit. ·The director of nursing services/designee is responsible to ensure compliance **What measures will be put into place or what systemic changes you will make to ensure the deficient practice does not recur:** · The licensed nurses will be re-educated by the DNS/designee (2/7/12) on notification of a resident's Physician for Dietary recommendations including	

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	Medication Administration Record (MAR) as specified by the RD in the progress note and were documented by the nursing staff as being conducted as according to the RD's recommendations, effective on 1-17-12. In interview with the Staff Development Nurse on 1-24-12 at 10:25 a.m., she indicated she had "found the current flush orders for the G-tube and the J-tube on the MAR, but no [physician] order for it...looks like whoever did the MAR didn't get the recommendations sent to the doctor to sign." She indicated the facility normally would have the RD provide her recommendations, then those recommendations would be faxed to the physician for their signature or would have the physician sign an order for the recommendations when the physician was in the facility. She indicated she would ensure a clarification order would be forwarded to the physician in regard to the feeding and flush orders, based on the RD's recommendations. In interview with the Director of Nursing Services on 1-26-12 at 10:32 a.m., she indicated the facility does not have a specific policy which indicated "clear and accurate documentation." The Medical Records Director provided a policy on 1-26-12 at 11:26 a.m. entitled,		approval prior to documenting in the medication administration and institution of the recommendation. Post test included. ·Dietary recommendations will be given to the DNS/designee by the RD prior to RD exit day of visit to obtain physician order. ·Every recommendation will be given to the DNS to ensure proper follow-up of physician's orders. ·The director of nursing services/designee is responsible to ensure compliance. ·Non-compliance will result in further education including disciplinary action. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur:** ·The CQI audit tool for Dietary recommendations as well as change of condition will be utilized daily x 4 weeks, bi-weekly x 2 months, monthly x 3 months and for 2 quarters thereafter for any resident who receives a dietary recommendation. ·Findings from the CQI process will be reviewed monthly and an action plan will be implemented for threshold below 95%. **Date of Compliance: 2/6/2012**	

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	"Documentation Guidelines," with a revision date of 2/2011. This policy indicated, "Purpose: To accurately document in an organized manner all information related to the resident in the medical record." This Federal tag relates to Complaint IN00102884. 3.1-50(a)(1) 3.1-50(a)(2)			